

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012730		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2012	
NAME OF PROVIDER OR SUPPLIER WOODVIEW HOME CARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3417 E STATE BLVD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>This was for a home health initial Medicaid survey. Based on the number of active patients listed, it was determined the agency did not meet the requirements of 7 active skilled patients at time of survey. The initial Medicaid survey was stopped on 12/13/12 at 1:35 PM.</p> <p>Census Service Type: Skilled: 2 Home Health Aide Only: 1 Personal Services Only: 1 Total: 4</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>On 12/12/12 at 0915, the surveyor entered facility. An entrance conference was concluded at 0940. At 10:05 AM, the facility indicated they only had 4 active patients but had 29 total since initial state survey in March, 2012. At approximately 3:00 PM, facility provided the Facility Census- Home Health form which indicated the agency only had 2 skilled patients. Supervisor notified 12/13/12 at approximately 8:30 AM and supervisor instructed to explain they did not have the required number of patients to continue with the survey. Facility notified at 10:55 AM of required number of active patients in order to conduct initial Medicaid survey. Employee F indicated they had been told they had to have 7 skilled patients since opening. The facility provided a list of 7 discharged skilled care patients. Two names on the list were Home Health Aide only, not skilled, patients. The agency and the Acute Care Supervisor had a discussion via phone at 1 PM. At 1:35 PM, the initial Medicaid survey was stopped as the agency</p>			G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 000	Continued From page 1 did not meet the requirements. Quality Review: Joyce Elder, MSN, BSN, RN December 18, 2012			G 000			